District of Columbia Department of Mental Health

The Training Institute
Office of Programs and Policy
64 New York Avenue, NE, 4th Floor
Washington, DC 20002

Compliance Community of Practice Minutes
Monday, April 21st 2-3:30 PM

Participants:

Sadie Bianco, RCI DCCC
Beth Crawford, Psy.D., MD/DC Family Resource
Tony Crews, DMH
Robert Frasier, Ph.D., MD/DC Family Resource
David Freeman, Community Connections
Venida Hamilton, DMH
Denise Harrison, Youth Villages
Stellvonne Jackson, Woodley House, Inc.
Arnetta Legree, VOAC
Andres Marquez-Lara, Green Door
Michael Mills, MD/DC Family Resource
Melanie Mitchell, Family & Child Services of WDC
Lynne Person, DMH
Audra Phalen, Pathways to Housing DC
Patricia Porter, DMH
Sarah Rabinowitz, Georgetown University Hospital
Sharon Richardson, LCSW, MD/DC Family Resource
Mary Thornton, Mary Thornton & Associates, Inc.
Erika Van Buren, DMH

I. Dr. Erika Van Buren, Director of Organizational Development, DMH, made introductions and defined the community of practice:

1. **What is a Community of Practice?**

- At the forefront of how organizations manage and share information, produce a collective knowledge about "how things are done."
- Etienne Wenger, social learning theorist, coined the term and defines them as "groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise by interacting on an ongoing basis."
- A COP is informal, open to all practitioners, works as a mutual help society rather than having a shared performance contract, and has a means of constant virtual communication rather than relying on occasional formal meetings.
- The specific goals of the DC DMH Compliance COP are to:
  - Facilitate peer mentoring among administrative, provider and support staff specifically responsible for assuring agency compliance with MHRS and DMH policies and regulations;

- Identify and discuss compliance-related issues for problem-solving, strategy development, and best practice sharing;
- To provide technical assistance resources and tools intended to improve compliance and quality of service delivery; and
- To engage in other mutually assisting activities that promote and improve access, availability, quality and outcomes to the populations we serve.

- Owned by the participants – not a way for DMH to monitor provider
- OA not present on the call
- Will be used to assess and monitor other training and technical support needs related to compliance.
- Now that you have registered for the COP, we will automatically add you to the distribution list for this call, and you will receive notices, minutes, TA resources and supports

2. What is the format and structure for the Compliance COP

- Mary Thornton will serve as COP facilitator – members will determine direction and topics for future calls.
- Monthly conference call (no call during July and August)
- How will we communicate? Electronic communication. Compliance-related questions can be sent to the DMH Training Institute e-mail address (dmh.training@dc.gov). Mary Thornton and the DMH Training Institute (TI) staff will select topics for future calls, based on questions and feedback given on the calls.
- The DMH Office of Accountability will not be on the calls, to provide safe environment for callers to address compliance-related issues without fear of evaluation. OA has designated a liaison to communicate relevant information to call participants.
- Mary Thornton and the DMH TI will work to revamp compliance FAQ's to have answered on the call.

II. Mary Thornton presented three steps to development of auditing and monitoring plan. (See PowerPoint Slides for detailed descriptions)

- Step I: Conduct a baseline review of medical records – CEO's and CFO Roles. Thornton described the benefits of conducting a baseline review, as well as the critical roles of CEO's and CFO's in this process. The baseline is recommended by the Office of the Inspector General as a first step for organizations in developing a compliance program. It outlines the risk profile of the organization and allows for resources to be directed at high risk areas.
- Step II: Monitoring. Thornton discussed the benefits and types of internal controls related to compliance. The outcome should be on-going data that describes the reduction of the various risk areas through trended numbers that show greater compliance with policy and a reduction in the numbers of inappropriate behaviors. Compliance officers should try to make sure they use data that is already being gathered so that efforts do not need to be duplicated. For example, many QI initiatives have a compliance component and their notes and measurements could be used by compliance. There are also some essential monitoring efforts that need to be made by all organizations. These include the robustness of the internal controls that have been developed to manage risk around completion of documentation, securing prior approvals, etc.

- Step III: Auditing. This is more expensive and requires additional planning. Auditing is a term that describes the process of choosing a random sample from a population, developing and using an audit tool and then confirming that specific attributes in the documentation exist. The sample is chosen is such a way as to give the receiver of the audit findings a high level of confidence in the accuracy of the findings. The DC DMH uses a sampling program developed by the federal government called RAT STATS. This program is available on –line. Thornton suggested that providers set up their baseline and monitoring efforts first before moving on to auditing. She warned that auditing can be very expensive so you want to use this resource judiciously.

With all auditing and monitoring efforts it is important to build slowly and not overwhelm the organization. Build a schedule that the organization can afford and can keep going.

III. Review of DC DMH new audit tools. (See Excel Spreadsheets)

- **DMH Claims Audit Tool (DRAFT)**
  - Delineates which MHRS, DMH or Dixon regulation requires the presence/accuracy of specific documentation
  - Internal agency monitoring and auditing processes should incorporate the variables assessed by the claims audit tool
- **DMH Quality Review Tool (DRAFT)**
  - Delineates the quality of care issues that DMH is concerned about
  - Fidelity is critical to meeting conditions of payment

IV. Questions and Discussion

1. Question and Answer

- Question: Prescriptions – do all services have to be prescribed by the psychiatrists? No, you have four licenses which can approve– the APRN, licensed psychologist, licensed social worker, and psychiatrist. You have an order for the services, in the specialty services. However, it is important to remember that these licensed individuals can only order within the scope of their license under state law. For specialty providers the rules are different. They follow the master treatment plan from the CSA. The CSA must order the service and then the specialty provider develops a care plan that is specific to their services only. It is important for the specialty provider to ensure that they have an ordered service. This requirement was waived for CBI and ACT services which can develop their own master and specialty treatment plan.

2. Suggestions for Future Calls

- Increasing consumer involvement in the process. Look at best practices in this area
- Request educating CEO/CFO on the differentiation between community support and case management. The current definition of community support does not allow for case management to. Develop a cheat sheet for CEO/CFO's to distinguish this.

V. News and Logistics of the COP

- Mary Thornton and DMH TI will take a closer look at the FAQ's (be patient we are resurrecting the old and working on new ones)

- Topics for FAQ's and next COP call were discussed. Participants were encouraged to submit suggestions via e-mail.
- Next Call: Tuesday, May 27th 2-3:30 PM. June and September calls will be scheduled.